VERMONT AGENCY OF HUMAN SERVICES
DEPARTMENT OF HEALTH

CERTIFICATE OF APPROVAL APPLICATION/ PROPOSAL FOR VSH FUTURES CRISIS STABILIZATION/ INPATIENT DIVERSION BEDS COVER PAGE

Applicant: Counseling Service of Addison County

Project Title: CSAC Crisis Stabilization Supported Residential Proposal

Principal Contact: Alexander Smith

Address: 89 Main Street (street) Middlebury (town/city)

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PROJECT TYPE & AMOUNT

- ☐ Capital expenditure exceeding $1,500,000 for construction, development, purchase or long-term lease of property or existing structure
- ☐ Purchase of a technology, technology upgrade, other equipment or a renovation with a cost exceeding $1,000,000
- **X** The offering of a health care service having a projected annual operating expense that exceeds $500,000 for either of the next two budgeted fiscal years if the service was not offered by the health care facility within the previous three fiscal years.

A. Proposed Capital Expenditure (Total Table 1) $ 462,550

B. Proposed Lease Amount (payment times term) $_____ I certify to the best of my knowledge and belief, that the information in this application is true and correct and that this application has been duly authorized by the governing body of the applicant.

CERTIFYING OFFICIAL: Robert S. Thorn PhD
Executive Director
Counseling Service of Addison County

SIGNATURE: _____

DATE: _____

Proposal Introduction and Overview

The Community Rehabilitation and Treatment (CRT) Program of the Counseling Service of Addison County (CSAC) is proposing a two bed crisis stabilization program co-located with a new six bed supported residential program. These two new capacities will address longstanding gaps in our local community service system and will also serve to help alleviate pressures on the statewide system of care. By co-locating these programs we are able to address these high priority needs at a scale appropriate to the needs of our region and with the efficiencies of combining core staffing and infrastructure.

The crisis stabilization program will be guided by recovery values and will offer a supportive treatment environment for individuals coping with destabilizing experiences of psychiatric symptoms, with the benefit of proximity to their families, communities, and treatment teams. The program will provide, in many instances, a cost effective alternative to inpatient care.

We have found an extraordinary setting for these programs. This eight bedroom family home was designed to also serve as a setting for home based residential support and will be ready for the services we are planning with no renovation. It is a beautiful and uplifting setting located in a clearing on a wooded hillside with striking views of the Otter Creek valley and the Adirondacks in the distance. The interior is sufficiently spacious to allow for different needs and program functions.

Program Features

- Staff support – at least 2 staff present 24/7
- Psychiatric and other medical service access and coordination
- Environment, resources and services supportive of recovery, wellness, and stress reduction
- Access to family, community and known treatment providers
- Access to peer support

PROPOSAL NARRATIVE

1. **Required Program Elements for Crisis Stabilization / Inpatient Diversion Bed Capacity.**

1.1 The service or programs proposed by the applicant for this RFP will be completely voluntary. How will prospective clients be encouraged to use the program?

This program will be guided by recovery values which include an emphasis on collaborative service planning. We believe the effectiveness of the setting will be contingent in large part upon the quality of the dialogue and collaboration between consumer and staff in identifying what strategies and supports would be most useful in coping with the psychiatric crisis in that setting.

For this reason, in most circumstances the client would be informed of this option in the context of discussions with their primary treatment team including therapist, case manager, and psychiatric staff, or with Emergency Team clinicians in response to immediate needs. Consumers will be encouraged to consider this resource as part of ongoing proactive crisis planning as well as in immediate response to emergent needs.

Written information about the program will also be available both as a pamphlet and on the agency web site.

1.2 How will the new crisis bed capacities proposed function as part of the larger care management system and system of care?

We will strive to maintain consistency with standards of care and practices associated with this level of care in Vermont including assessment, placement, continued stay and discharge guidelines, and we will collaborate with the broader care management system regarding resource utilization and availability.

We believe this program will serve as a local resource that will help to take pressure off of other capacities in our state system of care in both diverting and shortening inpatient stays. In addition, we will be available for referral from other regions when capacity is available and when the referral is clinically appropriate for this setting.

While not directly related to the issue of crisis bed capacity, the residential program we will be co-locating with the crisis bed program will also be a valuable resource to the system of care.

1.3 Who will be served in the program? How will the applicant assure that the program is available to respond to the general needs of the adult acute mental health care system and is available to individuals 18 and older, not limited to CRT consumers?

The program will be available to individuals 18 and older and will not be limited to CRT consumers. We anticipate that referrals will often be initiated by the Emergency Team which works with non-CRT consumers in crisis, as well as CRT consumers. Referrals will be screened based on availability and appropriateness for this level of care. A key factor in determining appropriateness for this level of care will be the willingness and assessed ability of the client to safely and effectively work with this program.

Our experience with crisis bed programs in Vermont has been that these programs have been most effective as local capacities where placements are informed by a base of relationship and understanding between consumer and referring and treating staff. This program will also be available for referrals from outside our catchment area given sufficient assessment supporting the conclusion that the placement is clinically appropriate. These assessments will need to include clear psychiatric planning and consultative availability from the referral source, and the referral will need to include clear discharge plans and time frames.

The program will be welcoming of people who are also coping with co-occurring substance abuse disorders provided there has been sufficient screening determining that they are not currently significantly impaired and that there are not other immediate health and safety risks. The program will expect clients to cooperate in maintaining a safe, alcohol and street drug free environment.

1.4 How will the program provide:

a) Daily medical oversight

Onsite RN staffing and oversight is built into the core staffing of the proposal. Staff will support residents in accessing appropriate medical services as needed. CSAC has developed a strong collaborative relationship with area physicians, including reciprocal referrals, and with our local ER. Also, our Eldercare clinicians work closely with physicians to coordinate medical care for older clients. These established relationships will benefit consumers in the proposed crisis program.

b) Daily access to a psychiatrist

CSAC has comprehensive psychiatric coverage. Psychiatric consultation will occur as needed face to face at agency sites, at Porter Hospital with transportation assistance, and on-site in some circumstances. Funding is included in this proposal to support additional back up psychiatric coverage to reflect the increase in crisis treatment and consultation that will be needed with this program.

c) Peer services and support

We will look for further consultation with our Client Advisory Team, our Recovery Committee, and Vermont Psychiatric Survivors (VPS) for the best way to address this need. The budget does include some funding for an adjunct contractual arrangement for peer services. We currently have wellness and recovery support groups organized around various topics at Evergreen House which will be a relevant resource. We have three trained recovery educators on the CRT staff and continue to encourage and support consumers in pursuing this training. There is a local peer support group that is ongoing. There are a number of 12 step groups in the area. Program staff would assist clients to get to peer support meetings such as these. As is our practice, we will welcome personal histories of having coped with psychiatric disorders as very relevant experience for applicants for positions in this program.

d) Adequate staffing

The staffing pattern designed for the combined crisis bed residential project entails a minimum of two staff onsite 24/7 with capacity to increase staffing as needed during more active times. The focus of staffing and supports will be weighted according to the level of care needs of the residents there with no more than three crisis bed and intensive support residents at any time. Other residential beds will be limited to lower levels of care needs.

The current program budget includes funding for RN and clinically trained staff with one of these two positions also serving as on-site program management.

1.5 What specific treatment and support modalities will be offered and how do these relate to the clinical mission of crisis stabilization and inpatient diversion?

The program will be trauma informed in design and guided by recovery values. Staff will be trained for capability regarding co-occurring mental health and substance abuse disorders as well as in crisis de-escalation methods. Staff training and resource availability will emphasize recovery and wellness coping skills, and stress reduction strategies.

As part of referral, clients will be encouraged to identify current prompting stressors and/or goals to work on addressing towards stabilization. Staff on-site will work together with the client and their treatment team in support of those directions identified. The extent to which treatment occurs onsite, at an agency site or elsewhere will vary according to the specific needs of the situation.

There will be active service coordination with clients' primary treatment teams and other support systems as appropriate around referral, treatment, and discharge planning.

1.6 How will the proposed crisis bed program provide as much capacity as possible within appropriated resources?

The on-site program manager will manage capacity and lengths of stay. Clients entering the program will develop an initial plan that will include treatment directions referred to above and an initial assessment of duration of stay. Generally the framework will be to work within a two to seven day time frame with the possibility to make extensions if needed in unusual circumstances.

The program manager will attend program meetings to coordinate this capacity with other program capacities and needs. They will also be directly linked to state care management systems and practices as they are developed.

By co-locating this program with other levels of care we are able to use the same core staffing and the same setting to cover these different needs of our service system and do so at as cost effectively as possible at a scale appropriate to the needs of our region.

1.7 Please provide the proposed admission, discharge, and continued stay criteria for the program. Describe how referrals and discharges will be decided consistent with the inpatient diversion and step-down outcomes of the program.

The program is intended to serve as a crisis stabilization and inpatient diversion program and referrals and continued stay decisions will in part be guided by that purpose. We will coordinate and calibrate our criteria and assessment tools used with the state care management system. In considering referrals we will look to be of assistance with situations where an individual is experiencing life destabilizing symptoms or stressors and is willing to work on safely coping with these experiences in this setting. We will also be available for step down from an inpatient stay where a gradual return to a less structured setting would be helpful, or where there are mitigating circumstances that are otherwise delaying discharge. We would also like to note that as inpatient settings are under considerable pressure to work with shorter lengths of stay, transitions back to the community can often be a vulnerable step in the process of recovery where short term step-down support can be a very useful and necessary resource.

In considering continued stay and discharge, we will review the degree of acuity vs. stabilization, the initial time frame agreed to, and our general guidelines for maximizing resource availability, and consider these factors together with current information regarding other individual's needs for the resource.

1.8 How will the program be cost effective, including?

- *leveraging resources with existing programs in the network of Designated Agencies and Vermont's hospitals,*
- *coordinating with existing facilities and programs, and*
- *sharing medical resources*

By co-locating with other residential capacities which will be in part funded by a shift of some existing case rate allocation from contracted residential services we are leveraging significant current funding to create the efficiencies of combined infrastructure that this proposal offers. We also will be doing a high degree of coordination with and sharing of existing program and agency services such clinical services, case management and community support, recovery programs at Evergreen House, Emergency Team services, and psychiatric services.

1.9 How will the program secure ongoing input from local program standing committees for program development and policy?

Our Client Advisory Team has received monthly updates of this developing proposal and has offered ongoing feedback and guidance. It is expected that this group would continue to advise regarding program development and policy for this project in the context of their monthly meetings. It will also be an option, if this project's funding is approved, to create a subcommittee to help guide planning, hiring, and implementation.

1.10 Additional Considerations

In addition to consistency with the program characteristics and principles described above, review criteria for the RFP will also include the following considerations:

a) Proposals that promote geographic access to the following high priority locations in the corridors between White River Junction and north, and between Burlington and Bennington.

b) Proposals that are prepared to develop a program on an immediate time frame.

c) Proposals most successful in leveraging the capacity of existing resources (such as hospitals and other programs that operate 24-7) with these new funds.

d) Proposals from designated agencies that do not have crisis bed programs currently.

e) Proposals from designated agencies that may have a crisis bed program but require a second location to assure access within reasonable distances.

f) Proposals that offer both local and statewide access

Our program will be located in a priority corridor. The property we are considering is in walk-in condition and would need no renovation to start. If funded, we can begin the program as soon as we can complete the purchase and hiring and training of staff. We

will be leveraging our existing case rate residential funding capacity, as well as shifting funding from unfilled staff positions, and would bring online other residential capacity that will also serve the needs of the broader system of care. We are an area that does not have other crisis bed services. We would be willing to take referrals from outside our catchment area when clinically appropriate to do so.

2. Facility Details and Program Costs

Describe the facility and location for the planned service. Specify the capital and operating costs resulting from the project. Please keep this statement reasonably concise and provide the following applicable details:

2.3 For projects involving the refinancing of existing debt (if applicable):

a) Describe the terms of both old and new debt, interest and maturity.
b) Demonstrate cost savings of refinancing or describe reasons for refinancing.

The setting we are considering for this proposal is an eight bedroom house south of Middlebury that was designed and built by a family who for many years have been residential and crisis bed providers, and who designed the building to serve in that function. The building is not only ADA accessible but also has some assistive technology available for people with physical limitations. The spacious layout of the house is conducive to the co-locating of different residential services. There are two large living spaces, a porch, much yard space and woodlands.

There is good natural light in every room and a striking view of the Otter Creek valley below. The setting is very uplifting, peaceful, and in our opinion, is an environment that is very supportive of recovery.

3. Local Governance Support and Relationship of Proposed Project to Agency Strategic Plan: COA Criterion 1

3.1 Please provide information about how this proposal was reviewed and approved by the applicant's Board of Directors and the appropriate Local Standing Committee or Committees.

The need for a local crisis stabilization bed program has been a priority concern of our Client Advisory Team for many years. They have been actively following, informing, and supporting the development of this proposal. This committee has also been highly supportive of addressing the need for more supported housing in our area.

The framework of this proposal has been presented to our board and they support our continuing to go forward in responding to these priority needs of our local communities in this way.

3.2.1 Please describe how this proposal is consistent with your agency's Strategic Plan or System of Care Plans. Please describe any public input or involvement that your agency has participated in or invited as part of the development of this proposal.

This proposal directly addresses two major goals in our 2004 and 2007 Local System of Care Plan: the need for a locally based crisis stabilization program, and the need for increased supported housing in our area.

3.3 If the proposal involves any new or reorganized services, describe how they will be coordinated with other services or providers in your area?

This program will be managed by the CRT Program at CSAC and will be coordinated with other agency and community services through existing infrastructures and practices. The program will have its own coordinator who will be supervised by the CRT Director or designee.

4. Need for the Proposed Project: COA Criterion II

4.1 Please describe how this proposal is consistent with Vermont's Health Resource Allocation Plan (H-RAP).

We believe this proposal well reflects all of the guiding principles identified in H-RAP in that we are creating a resource that will be "safe, effective, patient-centered, timely, efficient, and equitable", and is aligned with the high priority ranking H-RAP gives as quoted in the "Crisis Beds Development Work Group Report" to "allocating more resources to emergency services, given the intense need of services during the first hours

of a psychiatric emergency and the reduction of inpatient admissions that could occur as a result of a well-coordinated emergency service system."

4.2 As this project is in response to a Request for Proposals, it is not necessary to demonstrate need for new crisis stabilization / diversion beds. Instead, please describe how the program will meet the primary outcomes of reducing and diverting psychiatric inpatient use. What specific targets, from the outcomes listed below, will the program meet?

a) Reduce inpatient psychiatric admissions to VSH and General Hospitals
b) Reduce the number of inpatient days at VSH and General Hospitals

While our population base is too small to make statistically valid predictions, and there are many variables that could easily skew averages, we are cautiously estimating that this resource could result in a 30-50% reduction in both psychiatric hospital admissions and bed days for the CRT population, and a possible additional 20-25% reduction of other adult psychiatric hospitalizations.

Please describe the methodology and data employed to develop these outcome targets.

At the request of the Crisis Beds Development Work Group associated with the Futures Project we were asked to review hospitalizations over a six month period and determine how many of them could have been diverted or shortened if we had a crisis bed program. Based on this review, which included case specific discussions with clinical staff, we estimated that 10 of 17 CRT hospitalizations could have been averted or shortened as well as an additional 13 of 64 other adult non-CRT hospitalizations that could have been averted or shortened. The estimated bed day reduction for that period for the CRT population was 42%. These numbers do not reflect diversion to less appropriate settings or the adverse outcomes that can result from limited options for consumers who have a strong desire to not go to a psychiatric hospital and who end up not accepting much needed care.

Less measurable secondary savings associated with additional choice and empowerment, treatment continuity, and proximity to family and community should also be considered

4.3 Please describe how service utilization and program effectiveness will be reviewed?

The program will keep data on referrals, lengths of stay, and degree of stabilization and symptom reduction. This data together with consumer satisfaction data, complaints, and aggregate hospitalization data will be analyzed as part of ongoing utilization and quality improvement processes, and will include periodic reviews with the Client Advisory Team.

5. Organizational Structure, Affiliations and Operations: COA Criterion III

5.1 The entity making this application / proposal must be a Vermont Mental Health and/or Developmental Services Designated or Specialized Service Agency.

6. Financial Feasibility and Impact Analysis: COA Criterion IV

6.1 Please describe how the project will provide maximum service capacity within available resources.

In addition to submitting the attached financial tables, please provide any narrative information that you believe would help illustrate the financial impact and feasibility of this project. If the tables reflect anything significant that requires an explanation or clarity, please address this in the narrative.

As has been described above, we think this proposal creates some highly needed and very cost effective resources at a scale appropriate to our regional level of need. By combining the functions covered by staff in the same setting we feel we are creating as efficient and effective a model as possible given the availability of resources.

The financial tables included reflect both overall costs of the combined programs and a break out of costs specific to the crisis bed program. These estimates may vary somewhat as we go forward. We will look for opportunities to keep expenses as low as possible. For instance, we are planning to contribute approximately $50,000 to secure the facility and finance the balance. Securing additional capital assistance for the acquisition would help to reduce ongoing operating expenses and would over time positively impact the annual operating budget.

6.2 Were any alternatives to this proposal considered and, if so, why were they rejected? Explain why you believe there are no other less costly or more effective alternatives to be considered.

Over the past few years our program has studied many possible options for developing a local crisis bed program, and we have had a committee working continually over the past two years. Given both the geography of our county and the history in Vermont of how crisis bed programs have been most effective, we believe that the only way there can be a crisis bed program that is an effective resource for Addison County residents is to have that capacity located within Addison County. We do not predict a level of utilization demand for this resource to warrant a four bed free standing program and for this reason have reached the conclusion that the most cost effective way to create two beds of capacity is in a setting where the costs of core staffing and infrastructure can be shared with other programs in that same setting.

6.4 Financial Tables

Please complete the following financial tables which are included in Excel format.

See attached Excel spreadsheets.

CSAC
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 1
PROJECT COSTS

Construction Costs	
1. New Construction	-
2. Renovation	-
3. Site Work	-
4. Fixed Equipment	-
5. Design/Bidding Contingency	-
6. Construction Contingency	-
7. Construction Manager Fee	-
8. Other (please specify)	-
Subtotal	-
Related Project Costs	
1. Major Moveable Equipment	-
2. Furnishings, Fixtures & Other Equip.	9,375
3. Architectural/Engineering Fees	-
4. Land Acquisition	-
5. Purchase of Buildings	450,000
6. Administrative Expenses & Permits	3,175
7. Debt Financing Expenses (see below)	-
8. Debt Service Reserve Fund	-
9. Working Capital	-
10. Other (please specify)	-
Subtotal	462,550
Total Project Costs	**462,550**

Debt Financing Expenses	
1. Capital Interest	-
2. Bond Discount or Placement Fee	-
3. Misc. Financing Fees & Exp. (issuance costs)	-
4. Other	-
Subtotal	-
Less Interest Earnings on Funds	
1. Debt Service Reserve Funds	-
2. Capitalized Interest Account	-
3. Construction Fund	-
4. Other	-
Subtotal	-
Total Debt Financing Expenses	-
feeds to line 7 above	

CSAC
CERTIFICATE OF APPROVAL APPLICATION TABLES
FINANCIAL TABLES JANUARY, 2007
LIST OF TABLES

CSAC
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 1
PROJECT COSTS

Construction Costs	
1. New Construction	-
2. Renovation	-
3. Site Work	-
4. Fixed Equipment	-
5. Design/Bidding Contingency	-
6. Construction Contingency	-
7. Construction Manager Fee	-
8. Other (please specify)	-
Subtotal	-
Related Project Costs	
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4. Other	-
Subtotal	-
Less Interest Earnings on Funds	
1. Debt Service Reserve Funds	-
2. Capitalized Interest Account	-
3. Construction Fund	-
4. Other	-
Subtotal	-
Total Debt Financing Expenses	-
feeds to line 7 above	

CSAC
TABLE 2
DEBT FINANCING ARRANGEMENT
SOURCES & USES OF FUNDS

Sources of Funds

1. Financing Instrument	commercial loan			
a. Interest Rate	7.5%			
b. Loan Period	Jul 2007	To:	Jul 2037	
c. Amount Financed				391,800
2. Equity Contribution				58,200
3. Other Sources				
a. Working Capital				12,550
b. Fundraising				-
c. Grants				-
d. Other				-
Total Required Funds				**462,550**

Uses of Funds

Project Costs (feeds from Table 1)	
1. New Construction	-
2. Renovation	-
3. Site Work	-
4. Fixed Equipment	-
5. Design/Bidding Contingency	-
6. Construction Contingency	-
7. Construction Manager Fee	-
8. Major Moveable Equipment	-
9. Furnishings, Fixtures & Other Equip.	9,375
10. Architectural/Engineering Fees	-
11. Land Acquisition	-
12. Purchase of Buildings	450,000
13. Administrative Expenses & Permits	3,175
14. Debt Financing Expenses	-
15. Debt Service Reserve Fund	-
16. Working Capital	-
17. Other (please specify)	-
Total Uses of Funds	**462,550**

Total sources should equal total uses of funds.

CSAC
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 3A
INCOME STATEMENT
WITHOUT PROJECT

	Latest Actual 2006	Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Revenues					
First Party	150,519	138,624	144,169	149,936	154,434
Other Insurance	361,239	481,844	501,118	521,163	536,798
Medicaid	4,158,160	4,733,337	4,922,670	5,119,577	5,273,164
Managed Medicaid (Incl. VHAP, PC Plus)	406,726	429,324	446,497	464,357	478,288
CRT Case Rate	1,900,205	1,959,874	1,772,991	1,840,285	1,895,496
Waiver	5,627,041	5,829,517	6,062,698	6,305,206	6,494,362
PNMI	-	-	-	-	-
Other Fee For Service	327,960	556,683	556,683	578,950	578,950
Federal Grants	160,087	144,000	144,000	144,000	144,000
Other State	806,431	808,811	808,811	841,163	841,163
DDMHS Grants	370,843	452,707	452,707	470,815	470,815
Local/Other	247,690	252,417	262,514	273,015	281,205
Total Revenues	14,516,901	15,787,138	16,074,858	16,708,467	17,148,676
Expenses					
Salaries	6,367,054	6,916,161	7,092,807	7,370,519	7,584,935
Salaries for Respite Workers	39,131	124,389	124,389	124,389	124,389
Clinical Contractual	382,655	556,006	578,246	601,376	619,417
Contracted Respite Workers	-	-	-	-	-
Fringe	1,965,284	2,409,730	2,471,935	2,567,332	2,641,044
Contractual Services	3,621,013	3,646,205	3,586,350	3,682,302	3,744,685
General Operating	673,674	867,574	902,277	938,368	966,519
ICF Tax	-	-	-	-	-
Program	195,338	225,091	234,095	243,459	250,763
VSH Bed Assessment	-	-	-	-	-
Travel/Transport	396,210	463,797	482,349	501,643	516,692
Building - Direct	449,454	578,180	601,307	625,359	644,120
Other Non-Operating	-	-	-	-	-
Transportation (Allocated)	-	-	-	-	-
Building - (Indirect Allocated)	-	-	-	-	-
Admin I (Allocated)	-	-	-	-	-
Admin II (Allocated)	-	-	-	-	-
Fringe (Allocated)	-	-	-	-	-
Total Expense	14,089,812	15,787,133	16,073,755	16,654,747	17,092,564
Net Operating Income (Loss)	427,089	5	1,102	53,720	56,111
Non-Operating Revenue	-	-	-	-	-
Excess (Deficit) of Rev Over Exp	427,089	5	1,102	53,720	56,111